MEDICAL/EMERGENCY NOTIFICATION

Please complete this form prior to the first day of class.

Name: _____ Date: _____

Title: _____ Work Phone: _____

Department/Agency: _____

Address: _____
(STREET) (CITY) (ZIP CODE)

Supervisor's Name/Title: _____ PHONE: _____

Residence While Attending Course: _____ PHONE: _____

Address: _____
(STREET) (CITY) (ZIP CODE)

Worker's Compensation Insurance Carrier: _____

Policy Number: _____ Phone: _____

Personal Physician: _____ Phone: _____

Address: _____
(STREET) (CITY) (ZIP CODE)

EMERGENCY NOTIFICATION

In the event of death, injury, or sudden illness while in class, I hereby request personnel of the Department of Justice to notify the person(s) listed below.

Name: _____
RELATIONSHIP DAY PHONE HOME PHONE

Name: _____
RELATIONSHIP DAY PHONE HOME PHONE

OTHER IMPORTANT MEDICAL INFORMATION

STUDENT'S SIGNATURE: _____ **DATE:** _____